Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

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Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

PHARMACY EXAMINING BOARD

OUT-OF-STATE PHARMACY LICENSE APPLICATION

☐ NEW PHARMACY APPLICATION

CURRENT WI LICENSE NO.: _____

☐ CHANGE OF OWNERSHIP ☐ CHANGE OF LOCATION

PLEASE TYPE OR PRINT IN INK.

APPLICANT: individual, partnership, association or corporation

DBA: Name or title under which business is operated. **(This must be the name on the pharmacy label.)**

TELEPHONE NO. ( )

FAX NO. ( )

PHARMACY ADDRESS: number, street, city, zip code

COUNTY

MAILING ADDRESS: number, street, city, zip code

NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS OR CORPORATE OFFICERS AND PERCENTAGE OF OWNERSHIP.
(Attach additional sheets if necessary.)

NAME	%	NAME	%

Pharmacy license number in state where the pharmacy is physically located. State: _____ License Number: _____

Enclose copy of current license, permit, or registration certificate issued by the regulatory authority of the home state or territory OR letter from such authority certifying the pharmacy's compliance with the pharmacy and controlled substances laws of the home state.

Enclosed (check one): ☐ license ☐ compliance letter

Managing Pharmacist

State License #

DATE OF PURCHASE OF PHARMACY - date of sale to be signed (For Change of Ownership only)

PROPOSED OPENING DATE (This is required for a Change in Ownership or Change in Location.)

PROPOSED CLOSE DATE OF CURRENT LICENSE # (This is required for a Change in Ownership or Change in Location.)

PHARMACY HOURS - Daily (open - close)

An out-of-state pharmacy shall provide a telephone number that allows a person in Wisconsin to contact the pharmacy during the pharmacy's regular hours of business and that is available for use by a person in Wisconsion for not less than 40 hours per week. The label of all prescription drug containers shiopped, mailed or otherwise delivered to a person in Wisconsoin must bear the telephone number of the out-of-state pharmacy.

Telephone No.: (_____) _____-_____

APPLICATION FEE: Please make check payable to Department of Regulation and Licensing and attach to application.

$53.00 Initial Credential Fee

For Receipting Use Only

Committed to Equal Opportunity in Employment and Licensing

Wisconsin Department of Regulation & Licensing

Statement of Owner or Managing Pharmacist

Statement from the owner of the pharmacy or;

If the pharmacy is not a sole proprietorship, from the managing pharmacist of the pharmacy;

This is to certify that I have read and approved the foregoing and the statements are true and correct to the best of my knowledge and belief; and that I know the laws relating to the practice of pharmacy in Wisconsin.

_____ _____

(Owner, if a sole proprietorship) Date

_____

PRINTED NAME

This is to certify that I have read and approved the foregoing and the statements are true and correct to the best of my knowledge and belief; and that I know the laws relating to the practice of pharmacy in Wisconsin.

_____ _____

(Managing Pharmacist, if not a sole proprietorship) Date

_____

PRINTED NAME

State License # _____